STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265834	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview and record review, the facility failed to provide care consistent with professional standards of practice when the facility failed to perform/document post-fall neurological assessment (an assessment that checks the resident's mental status, level of consciousness, pupil reaction, motor (movement) response to stimulation, and sensation) and complete post fall assessments per policy for one resident (Resident #105). The sample was 24. The census was 121. Review of the facility's Fall Management policy, date 2/28/23, showed: -An un-witnessed fall occurs when a resident is found on the floor and resident/employee is unaware how he/she got there; -Prior to moving the resident, the charge nurse will evaluate for injury; -Complete neurological evaluation post-fall on residents with potential head injury or unwitnessed fall; -Implement Post-Fall Evaluation/Documentation, all shift evaluation/documentation X72 Hours. -Potential Head Injury: charge nurse shall complete a neurological evaluation per instructions on resident's post-fall with potential head injury/unwitnessed. Review of Resident #105's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 3/14/25, showed: -Moderately impaired cognition; -Frequently incontinent of bowel and bladder; -Required substantial/maximal assistance (helper does more than half the effort) for activities of daily living (grooming, bathing, dressing, toileting, and transfers); -No functional limitation in range of motion (ROM); -Mobility device: wheelchair; -Diagnoses include medically complex condition. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan in use during survey, showed: -Focus: The resident is at risk for falls confusion, deconditioning, gait balance problems 3/12/25 fall, 3/24/25 fall, 3/29/25 fall, 4/17/25 fall no injury, 4/21/25 fall no injury, 4/28/25 fall no injury, 4/30/25 fall no injury, 5/13/25 fall without injury (slid out of wheelchair); -Goal: The resident will be free of minor injury through the review date; -Interventions included: -On 3/12/25, ensure personal items are within reach prior to leaving room; -On 3/24/25, bed in low position, call light within reach. Reminders to call for assistance prior to attempting to transfer or reaching for out of reach items; -On 3/29/25, room moved closer to nurses' station for closer observation; -On 4/18/25, ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair; -On 4/21/25, encourage and reminded to ask staff for assist with hygiene to prevent falls and maintain safety; -On 4/30/25, staff to ensure personal items are within reach; -On 5/14/25, physical therapy (PT) evaluate and treat as ordered or as needed. Review of the resident's progress notes dated 3/12/25 through 5/28/25, showed: -On 3/12/2025 at 9:30 A.M., during rounds, the nurse was informed by the certified nurse aide (CNA) that resident was on the floor after he/she slid off the bed while trying to grab some of his/her belongings from the bedside table. Assessed for potential injuries, none found. Checked for ROM, no issues, resident able to move all extremities. Neurological check done, resident alert and oriented x 3 (person, place, time), Pupils equal, round, and reactive to light and accommodation (PERRLA). Vital signs as follows: blood pressure (BP, normal was 130/80 through 90/60) 129/94, pulse (P, normal 60 through 100) 95, Respirations (R, normal 12 through 18) 19, temperature (Temp, normal 97.8 through 99.1) 97.7, Oxygen saturation (02 sat, normal 95 through 100%) 98% on room air. Assisted resident back to bed. Medical Doctor (MD)/Resident Representative (RR) notified: -Eight out of nine every shift post fall documentation, blank; -On 3/24/25 at 7:15 A.M., during shift change, the nurse was informed by the CNA (Certified Nurse Aide) that resident was on the floor after he/she slid off the bed while reaching for his/her stuff from the bedside table. Assessed for potential injuries, none found. Checked for ROM, no issues, resident able to move all extremities. Neurological check done, resident alert and oriented x 1 (person), PERRLA. Vital signs as follows: BP 118/75, P 77, R 18, Temp 98.0, 02 sat 97% on room air. Assisted resident back to bed, advised to use call light for assistance. MD/RR notified; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Eight out of nine every shift post fall documentation, blank; -On 3/29/25 at 2:37 P.M., BP 116/75, P 91, Temp 97.0, O2 sat 93% on room air, upon assessment patient observed lying on abdomen on the floor next to his/her bed. Patient was asked why he/she was lying on the floor next to his/her bed and patient stated that he/she was trying to get up and take his/ herself to the restroom. Patient was asked did he/she hit his/her head and patient stated that he/she did not. Patient was asked if he/she was in any pain and patient stated that he/she was not in any pain. patient's extremities were observed and no limitations. Patients skin was intact with no new changes. Patient's level of consciousness was intact. Patient alert and able to voice needs. Patient was assisted up from floor with two people assist and a gait belt and placed back into his/her bed patient received a shower and cleaned up and placed back in his/her bed with call light within reach and operable. MD made aware and gave orders for neurological checks. Neurological checks started and will be passed along to the oncoming nurse: -Eight out of nine every shift post fall documentation, blank; -On 4/3/25 at 8:03 A.M., patient was observed on the floor at about 2:15 this morning, by shift supervisor, patient was helped back into bed, assessment done, vitals within normal limits. Patient able to move all extremities without any facial grimace, patient did not voice any pain. MD and family member notified: -Six out of nine every shift post fall documentation, blank; -On 4/14/2025 at 4:30 A.M., on rounds resident noted on the floor at bedside. Positioned lying on his/her back. Bed in low position. No injury/abrasion noted. ROM within normal limits. Assisted back to bed without difficulty stated, I was going out. Oriented to place and time with some understanding noted. Denies any acute pain/discomfort. No acute distress noted. BP 134/81, P-93, R-18, O2 sat-98% on room air, Neurological check in place. Vital signs stable: -Eight out of nine every shift post fall documentation, blank; -On 4/17/25 at 1:30 P.M., patient's vitals obtained and noted. Neurological checks, ROM within normal limits. Patient denies pain, no apparent injuries noted, significant other, MD and Assistant Director of Nursing (ADON) made aware of fall: -Six out of nine every shift post fall documentation, blank; -On 4/21/25 at 3:30 P.M., Situation, Background, Assessment, Recommendation SBAR, is a structured communication tool used to improve communication between healthcare professionals, particularly when discussing a patient's condition or other urgent matters), showed: the change in condition/reported was falls, at the time of evaluation resident/patient vital signs was BP 137/97, P 92, R 18, Temp 97.3: -Five out of nine every shift post fall documentation, blank; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/28/25 at 11:56 A.M., CNA called to go to room, resident on floor, beside his/her bed, lying supine, alert, confusion present. Active passive range of motion (APROM) done x4 extremities, denies pain, no injuries noted. MD and RR made aware. BP-121/82, P- 92, R- 20. DON made aware. At 3:32 P.M., resident remains on incident follow up (IFU) for prior fall, complains of aches all over. Tylenol given as ordered, neurological checks within normal limits for this resident, no injury noted: -Five out of six every shift post fall documentation, blank; -On 4/30/25 at 12:00 P.M., during rounds, the nurse was informed by therapist that resident was on the floor after he/she slid off the bed while reaching for his/her phone. Assessed for potential injuries, none found. Checked for ROM, no issues, resident able to move all extremities. Neurological check done, resident alert and oriented x2, PERRLA. Vital signs as follows: BP 112/83, P 82, R 19, Temp 97.8, 02 sat 97% on room air. Assisted resident back to bed, advised to use call light for assistance. MD/RR notified: -Four out of nine every shift post fall documentation, blank; -On 5/7/25 at 8:59 A.M., resident was found on the floor at approximately 8:45 this morning. His/Her vital signs are stable, and he/she did not hit his/her head and there is no bruising or skin tears at this time. MD and family informed: -Five out of nine every shift post fall documentation, blank. During an interview on 6/3/25 at 11:30 A.M., Licensed Practical Nurse (LPN) C said for unwitnessed falls, he/she would assess the resident from head to toe checking for injury, pain, a change in ROM. He/She would ask the resident what happened and document the fall. The MD would be notified and the RR. Neurological checks would be completed per the scale on the form for 72 hours. During an interview on 6/3/25 at 12:20 P.M., the Administrator said the facility did not have any of the resident's neurological check sheets. The staff documented they were done but she could not find them. The Administrator would expect for staff to follow the facility's policy for falls and if the resident had any issues notify the supervisor. During an interview on 6/2/25 at 4:15 P.M., the DON said if the resident had an unwitnessed fall, she would expect for staff to follow the facility's policies and procedures, and notify the MD, RR. During an interview on 6/3/25 at 5:25 P.M. with the ADON, Corporate Nurse and the Administrator, the Corporate Nurse said she would expect neurological checks to be completed per the facility's policy and she would expect for staff to follow the facility's policies and procedures. MO00254710

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to provide care consistent with professional standards of practice, when staff failed to timely administer or document treatment orders and failed to document a description of the wounds on admission for one resident. (Resident #215). The sample was 24. The census was 121. Review of the facility's Wound Management Policy, dated 11/15/22, showed: Policy: To promote wound healing of various types of wounds, the facility will provide evidence-based treatments in accordance with current standards of practice and physician orders; -Charge nurse will notify physician in the absence of treatment orders; -Wound characteristics/documentation: -Location of the wound pressure injury & stage; -Size (Shape, Depth, Tunneling and/or Undermining). Volume & Exudate (drainage) characteristics; -Pain evaluation; -Presence of infection/bioburden. -Condition of the wound bed & wound edges. condition of the peri-wound (area around the wound); -Treatments will be documented on the Treatment Administration Record (TAR). Review of the facility's Skin Integrity policy, dated 7/5/24, showed: Skin evaluations shall be completed upon admission and routinely, as per the care plan, to monitor skin integrity. Review of the facility's Nursing Admission/readmission Checklist, undated, showed: Complete skin assessment and initial wound user defined assessment (UDA). Interdisciplinary team (IDT) documentation should include notifying the medical doctor (MD), resident representative (RR) and Registered Dietitian (RD), of skin condition, preventative measures in treatment regimen. Review of Resident #215's baseline care plan dated 5/10/25, showed, note all skin issues was blank. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 5/13/25, showed: -admission date was 5/9/25; -Cognitively intact; -No behaviors or rejection of care; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included: anemia (decrease in number of red blood cells), heart failure, high blood pressure, diabetes, paraplegia (paralysis of the legs and lower body), renal failure; -Number of unstageable-deep tissue: suspected deep tissue injury (DTI) in evolution: Two, present on admission; -Number of Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough (dead tissue separating from living tissue) or eschar (dead tissue) may be present on some parts of the wound bed. Often includes undermining (wound open underneath the border of the wound) and tunneling (a deep, narrow channel that extends from the surface of a wound into the underlying tissues)): One, present on admission. Review of the care plan in use at the time of survey, showed: -Focus: The resident was admitted to facility with DTI to bilateral heels and a healing Stage IV to sacrum (a triangular bone at the base of the spine) related to immobility; -Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date; -Interventions included: Administer treatments as ordered and monitor for effectiveness. During an interview on 5/22/25 at 7:51 A.M., Physician P said the resident's main wound was located on his/her sacrum. The wound had been present since April 2025. When the resident was discharged to the facility and subsequently returned to the hospital, the ulcer was quite a bit larger. They could see via imaging that the infection had spread deeper. The resident would require six weeks of Intravenous (IV, administered into a vein) antibiotics. There was a lot of dead necrotic (dead) tissue on top of the wound bed. The resident would be undergoing surgical debridement (a procedure that involves the removal of dead or damaged tissue from a wound). Review of the hospital discharge summary for date of services 5/9/25, showed: Pertinent Consultations and Follow up Recommendations: Wound care, patient needs follow up for Stage IV sacral pressure ulcer. Recommend cleanse with wound cleanser or normal saline. Recommend apply triad (wound dressing) twice daily and as needed. Leave open to air or cover with secondary dressing. Air seat cushion for pressure injury on sacrum. Review of the progress notes dated 5/9/25 through 5/15/25, showed: -On 5/9/25 at 6:18 P.M., Alert and oriented times three (person, place and time). Skin: normal color, texture, no rashes or lesions; -On 5/10/25 at 10:09 P.M., 5/12/25 at 3:10 A.M., 5/15/25 at 1:09 A.M. and 5/16/25 at 2:42 A.M., Skilled evaluations: Skin, left blank. Review of the Wound Care Team notes, dated 5/13/25, showed: -Chief complaint: Resident presents with wounds on his/her sacrum, right heel and left heel; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Unstageable DTI of the right heel, undetermined thickness; -Wound size: 5.1 length by (X) 6 (width) by not measured (depth) centimeters (cm) -Treatment plan: Betadine, gauze sponge sterile and wrap with gauze roll and tape every two days and as needed if saturated, soiled or dislodged; -Unstageable DTI of the left heel undetermined thickness; -Wound size: 5 X 5.5 X not measured cm; -Treatment plan: Betadine, gauze sponge sterile and wrap with gauze roll and tape every two days and as needed if saturated, soiled or dislodged; -Stage IV pressure wound sacrum full thickness; -Wound size: 4.9 X 7 X not measured cm. Depth is unmeasured due to presence of nonviable tissue and necrosis; -Treatment Plan: Hypochlorous acid solution apply twice daily and as needed if saturated, soiled, or dislodged. Gauze sponge sterile apply twice daily and as needed if saturated, soiled or dislodged. Gauze island with bordered gauze (bdr) apply twice daily as needed if soiled. -Surgical excisional debridement, remove thick adherent eschar and devitalized tissue (no longer living), remove necrotic tissue and establish the margins of viable tissue. Additional note: Post debridement assessment of this previously unstageable necrotic wound has revealed the underlying deep tissue at the muscle/fascia level (connection tissue), which had been obscured by necrosis prior to this point. This wound has now revealed itself to be Stage IV pressure injury. This is not a wound deterioration. Review of the resident's progress notes, showed on 5/15/25 at 9:37 P.M., seen by wound care team this week, new orders received and implemented to the TAR. RR and physician made aware will continue with new plan. Review of the physician order sheet, dated active as of 5/17/25, showed: -A physician order for wound consult as needed to evaluate and treat, start date was 5/10/25; -A physician order for unstageable DTI right heel, cleanse with wound cleanser, air/pat and dry, add betadine gauze sponge sterile wrap with gauze every two days and as needed for wound care. Start date was 5/15/25; -A physician order for unstageable DTI left heel, cleanse with wound cleanser, air/pat and dry, add Betadine (antiseptic) gauze sponge sterile wrap with gauze every two days and as needed for wound care. Start date was 5/15/25; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A physician order for pressure wound sacrum cleanse with wound cleanser, air/pat dry, skin prep to peri wound (the area of skin surrounding a wound), add wet to dry dressing (a type of wound dressing where saline-soaked gauze is placed in the wound, allowed to dry, and then removed) with Hypochlorous Acid Solution (antimicrobial) solution twice daily and as needed cover with island gauze dressing, if saturated, soiled, or dislodged for wound care. Start date was 5/16/25. Review of the progress notes dated 5/17/25 through 5/20/25, showed: -On 5/17/25 at 10:40 A.M., Skilled skin evaluation: Skin warm and dry, skin color within normal limits and turgor is normal; -On 5/19/25 at 4:52 P.M. Resident was sent to the hospital; -Staff did not document any description of the wounds upon admission. Review of the TAR, dated 5/9/25 through 5/20/25, showed -A physician order for Stage IV sacral pressure ulcer. Cleanse with wound cleanser or normal saline. Apply Triad(a sterile protective coating designed to be applied directly from the tube on to broken skin and/or the wound without the need of a secondary dressing) twice a day (BID) and as needed. Leave open to air or cover with secondary dressing. Every evening shift for wound care, start date was 5/10/25 and discontinued on 5/11/25; -No documentation for 5/10 and 5/11/25; -A physician order for unstageable sacral pressure ulcer, cleanse with wound cleanser or normal saline, skin prep to peri wound, apply Xeroform (petrolatum-impregnated gauze dressing), Calcium Alginate (wound dressing) cover with foam dressing everyday shift and as needed for wound care start date 5/13/25, discontinued on 5/15/25; -Staff documented the treatment was completed once daily. -A physician order for pressure wound sacrum cleanse with wound cleanser, air/pat dry, skin prep to peri wound, add Wet to Dry dressing with Hypochlorous Acid Solution twice daily and as needed cover with island gauze dressing, if saturated, soiled, or dislodged for wound care, start date was 5/16/25; -No documentation on 5/17/25 at 8:00 P.M. through 11:00 P.M.; -A physician order for unstageable DTI Right Heel, cleanse with wound cleanser, air/pat and dry, add betadine gauze sponge sterile wrap with gauze every two days and as needed, start date was 5/15/25 -No documentation on 5/15 and 5/17/25. On 5/19/25, staff documented OO (out of facility); -A physician order for unstageable DTI Left Heel, cleanse with wound cleanser, air/pat and dry, add Betadine Gauze sponge sterile wrap with Kerlix (a brand of gauze bandage rolls widely used in wound care) every two days and as needed, start date was 5/15/25; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation on 5/15 and 5/17/25. On 5/19/25, staff documented OO; -A physician order for pressure wound sacrum cleanse with wound cleanser, air/pat dry, skin prep to peri wound, add Wet to Dry dressing with Hypochlorous Acid Solution twice daily and as needed cover with island gauze dressing, if saturated, soiled, or dislodged for wound care, start date was 5/16/25; -No documentation on 5/17/25 at 8:00 P.M. through 11:00 P.M. Review of the progress notes dated 5/13/25 through 5/19/25, showed no documentation the treatment was changed or the physician was made aware there was a delay in the treatment being administered per physician order. During an interview on 6/2/25 at 5:18 A.M. Licensed Practical Nurse (LPN) K said the nurses on the floor were responsible for completing the treatments. Treatments are documented on the TAR. During an interview on 6/3/25 at 11:30 A.M., LPN C said when a resident was admitted to the facility usually one nurse would do the paperwork (enter all the orders into the computer and set up follow up appointments, etc.) and the other nurse completed the head-to-toe body assessment and vital signs. The skin assessments were documented in the computer under skin observation tool. There was a human diagram on the skin assessment and the nurse would document the location of any wounds and define what the issue was from the drop-down box . LPN C would describe what the wound looked like, the location, the stage and note if there was any tunneling. The physician would be notified, and orders would be obtained if the resident did not have orders from the hospital. The resident would be seen by the Wound Doctor on her next visit. When treatments were completed, they should be documented on the TAR. A blank on the TAR meant it was not done. During an interview on 6/2/25 at 8:45 A.M., the Wound Nurse said the floor nurses were responsible for providing the wound care. She scheduled the treatments and rounded weekly with the Wound Doctor. She was responsible for the weekly wound documentation. If the floor nurses noted a new wound or a change in the resident's wounds, they would notify her, and she would obtain the treatment orders. Or, whoever found the wound or change in the wound could call the physician and obtain orders. If the nurse was unable to complete a treatment, they would pass it on to the next shift or if she was at the facility they could notify her. Then, she would complete the treatment. The nurse should document on the TAR when the treatment was completed. If the treatment was not completed it should be documented and the reason why wound care was not provided. A blank on the TAR meant the treatment was not done. If NA (not applicable) was documented, the treatment still needed to be completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/2/25 at 4:15 P.M., the Director of Nursing (DON) said the facility did not always receive the discharge paperwork from the hospital at the time residents were admitted . A skin assessment should be completed on admission by the floor nurse. Any nurse could do a skin assessment. The Wound Nurse would see the resident the next day she was in the facility. The nurse should document a description of what the wound looked like. The nurses did not stage or measure wounds. If the resident came to the facility with a treatment order, the nurse should enter the treatment into the computer. If the resident did not have a treatment order, the Wound Nurse would see the resident the next day and call the physician to get an order. The floor nurse could also call the physician and get a treatment order. The facility had protocols in place for treatments until the resident could be seen by the Wound Doctor. The Wound Doctor visited the facility weekly. A blank on the TAR meant the item was not addressed. Staff should document if the treatment was administered or enter a code if it was not administered. The DON did not know why the resident's sacrum treatment was not documented as administered until 5/13/25 or why his/her heel treatments were not documented as administered until 5/19/25. The DON would expect for staff to follow the physician orders and the facility policies and procedures. During an interview on 6/3/25 at 4:28 P.M., the Wound Doctor said if a resident was admitted to the facility or a wound was found between her visits to the facility, the nurse should notify the facility's Wound Nurse and notify the resident's physician to obtain treatment orders. She visited the facility weekly, and her notes were uploaded into the facility computer system. The Wound Nurse and the DON had access to her notes. The Wound Doctor only saw the resident once and she ordered a simple dressing change to his/her heels to be changed every two days. The resident had a large necrotic area on his/her sacrum, and she order the dressing to be changed twice daily. The Wound Doctor was not aware the wound on the resident's sacrum was not documented until 5/13/25 or that there was no documentation for his/her heels until 5/19/25. The Wound Doctor would expect for staff to follow the physician orders and the facility's policies and procedures. During an interview on 6/3/25 at 5:25 P.M., the Corporate Nurse said when the facility received report from the hospital, the hospital would notify staff if the resident had a wound. If the resident did not have a treatment for the wound, the Wound Nurse would obtain the order. A description of the wound should be documented, which would include measurements, the stage of the wound, location and the type of treatment. A blank on the TAR meant staff did not check it off or they did not do the treatment. She would expect for staff to follow physician orders and follow the facility policies and procedures. MO00254618

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	265834	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident was free from additional harm after experiencing an unwitnessed fall. Staff transferred the resident back to his/her bed while the resident showed signs of injuries (Resident #8). The resident sustained fractures following the fall. In addition, the facility failed to transfer a resident (Resident #1) appropriately utilizing a mechanical lift. The sample size was 24. The census was 121. Review of the facility's Fall Management Policy, dated 2/28/23, showed: -Policy: To provide an environment that remains as free of accidents and hazards as possible. The Facility will complete a fall evaluation on Residents to determine who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent to minimize further falls and/or reduce injuries; -Definition: -A Fall is a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object; -An unwitnessed fall occurs when a Resident is found on the floor and the Resident/Employee is unaware of how he/she got there; -Prevention/Treatment: -Prior to moving the Resident, the Charge Nurse will evaluate for injury; -If injury is known or suspected; -Provide emergency first aid treatment as applicable. 1. Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/4/24, showed: -Cognitively intact; -No behaviors; -Required substantial/maximal assistance for mobility and transfers; -Diagnoses included anemia. Review of the resident's progress notes, showed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-2/13/25 at 9:16 P.M., the resident was found on the floor by staff. Resident stated he/she was trying to reach something on his/her bedside table and slipped out of bed. Resident denies pain at this time. No visible injuries. Denies hitting head. Resident refused to turn to be placed on Hoyer (mechanical lift) pad. Educated resident on the safety of using a Hoyer. Resident insisted to be lifted by two male staff to be placed back into bed. One male staff held his/her legs and other male staff held under his/her arms. Placed resident back to bed. Multiple staff present at the time. Resident refuses to have vitals taken. Notified doctor; -2/14/25 at 2:04 A.M., Doctor and evening shift supervisor notified. Resident is now having complaints of left arm pain, refusing to be changed by the Certified Nursing Assistant (CNA). Call made to physician for an x-ray. Resident notified; -2/14/25 at 8:55 A.M., X-ray to left arm/shoulder completed. Awaiting the results; -2/14/25 at 12:04 P.M., Received the x-ray results. This nurse called the doctor and reported the results. Resident has a non-displaced fracture involving the supracondylar left humerus (a break to the lower part of this bone, close to the elbow) that suggests metastatic disease. The doctor recommends sending the patient to the hospital. This nurse talked to the patient and explained that the doctor recommended he/she go to the hospital. Resident is alert and oriented and able to understand he/she has a fracture and is own responsible party. Resident declined going to the hospital and states he/she could wait and if it gets worse, then would go to the hospital; -2/14/25 at 3:24 P.M., the resident refused vital signs during this shift. Dr here and made aware. Continues to be assisted with activities of daily living; -2/14/25 at 9:23 P.M., the resident resiting in bed with the rise and fall of the chest. Resident complained of pain to the left arm. This writer offered resident a pain medication to help with pain. The resident declined pain medication. This writer had conversation with the resident on how he/she fell, and why he/she did not want to go to the hospital. Resident responded saying, I am afraid of what else they will find. This writer encouraged resident to go. Resident continues to decline offer stating is he/she changes his/her mind, he/she will let this writer know. Vital signs refused. Swelling noted. Offered to elevate arm. Resident declined medical doctor. Review of the resident's care plan, in use during the time of the investigation, revised 2/14/25, showed: -Focus: The resident is at risk for falls. 2/13/25 fall; -Goal: The resident will be free of minor injury through the review date; -Interventions: Anticipate and meet the resident's needs. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Review of the resident's progress note, showed: -2/15/25 at 2:38 A.M., resident requested to go to the hospital. Medical doctor made aware. Resident left facility via stretcher for complaints of pain to left hip radiating down his/her leg. Resident going to the hospital; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-2/20/25 at 4:07 P.M., spoke with staff at the hospital. Diagnoses of left distal femur fracture (thigh bone just above the knee joint) and left humerus fracture. No anticipated discharge date available at this time. Review of the resident's hospital Discharge summary, dated [DATE] at 10:14 A.M., showed: -Left distal femur fracture-occurred after fall out of bed experiencing dizziness; -Left distal humerus fracture. During an interview on 5/30/25 at 2:33 P.M. and 6/2/25 at 7:27 A.M., the resident said on 2/13/25 around 10:00 P.M., he/she reached for something on the night stand and fell from the bed, onto the floor. He/She screamed in pain and for help because he/she could not get to the call light. Two female staff members came to the room to assist him/her back in bed. They did not offer a Hoyer to transfer the resident back into bed. The resident said, If they did offer it, I don't know how they would have gotten me on it because I was in so much pain and the way my body was positioned would not allow a Hoyer to lift me without causing further pain. I was in so much pain, I would have refused a Hoyer anyway. The resident was not sure who the two staff members were, only they were from an agency and not regular employees of the facility. The staff members did not complete range of motion on the resident. They did not take vitals. The two staff got in position to transfer the resident back to bed. The resident said, something did not feel right when the staff were about to lift the resident. He/She asked the two staff members to stop and requested two male staff members transfer him/her back to bed. The staff members texted the male CNAs to assist the resident back into bed. Approximately five minutes later, CNAs Q and T entered the resident's room to transfer him/her back into bed. CNA Q grabbed the resident's legs while CNA T grabbed the resident's arm. The resident said CNA T grabbed him/her by the arm, under his/her elbow. As they lifted the resident, the resident said he/she felt a crack in his/her arm and yelled out, ouch, my arm, my arm, my arm! They then transferred the resident into the bed. The female staff said, they did not do anything to your arm. Make sure to document that they did not do anything to his/her arm. The resident said he/she was in so much pain after being placed in bed. An aide entered his/her room shortly after and said he/she needed to take vitals. The resident refused and said he/she was in pain. The resident was also distrustful of the aide because he/she said the resident was not in pain and did not want to work with the aide. He/She did not have any vitals taken due to pain. The next day someone came in and took x-rays. Later, the resident found out he/she had a fracture. He/She was afraid to go to the hospital and initially declined. That evening, Licenced Practical Nurse (LPN) O arrived and the resident told him/her what happened as he/she trusts LPN O. LPN O convinced the resident to go to the hospital. During an interview on 6/2/25 at 4:52 A.M., LPN O said he/she arrived to work the following day after the resident fell. The resident told him/her what happened the night before. LPN tried providing care to the resident and the resident cried out in pain. He/She encouraged the resident to go to the hospital. LPN O was not sure who the staff were who worked with the resident. He/She believed they were agency staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/2/25 at 7:04 A.M., CNA R said he/she was present when the fall occurred. He/She heard the resident yelling and saw him/her on the floor. He/She immediately got the nurse and explained the resident needed a mechanical lift and was on the floor screaming out in pain. He/She could not recall the nurse and said the nurse worked for an agency and had not returned since the incident. The nurse did not get a chance to obtain vitals because the resident refused and kept saying I am hurt and insisting staff get him/her off the floor. CNA R and the unknown nurse educated the resident on the importance of using the mechanical lift. Again, the resident refused. As they were going to lift the resident, the resident asked for CNAs Q and T. The aides arrived and lifted the resident off the floor and placed him/her back in bed. The nurse said he/she would document in the progress note the resident refused a mechanical lift and vitals. Later that evening, CNA R returned to the resident's room to get vitals. The resident refused and said he/she was in pain. He/She did not return to follow up on vitals as this was close to 10:00 P.M. when it happened and the shift was almost over. During an interview on 6/2/25 at 9:02 A.M., CNA Q said he/she and CNA T received a text message from the nurse asking for assistance in getting a resident off the floor. When they arrived, the resident was on the floor screaming in pain saying, It hurts, it hurts, it hurts. The resident also said to get him/her off the floor. At first, CNA Q said he/she did not recall the nurse doing range of motion because the resident was in so much pain and insisted on being transferred back to bed. They did not use a pad to transfer the resident. He/She could not recall exactly how the resident was lifted. He/She grabbed the resident by the legs and CNA T, who has since been terminated, grabbed the resident by the arms. He/She could not recall how the resident's arms were grabbed and how his/her body was positioned prior to the transfer. After transferring the resident back to bed, CNA Q continued with his/her assignments. During an interview on 6/2/25 at 9:21 A.M., LPN S said if there was an unwitnessed fall, the resident should be assessed by the nurse prior to moving the resident. If the resident is alert and oriented, denies pain, range of motion performed, vitals taken and no visible signs of injury, the resident could be transferred back into bed using a lift or pad. This was after a full head to toe assessment. If the resident was in pain, or showed signs of pain, it would be unsafe to transfer the resident back into bed. Staff should call Emergency Medical Services (EMS) if a resident showed signs of injury following a fall. During an interview on 6/2/25 at 4: 15 P.M., the Director of Nursing (DON) said if the resident complained of pain after a fall, staff should not attempt to move the resident and should call EMS immediately. During an interview on 6/3/25 at 5:25 P.M., the Corporate Nurse, Assistant Director of Nursing and Administrator said staff should have contacted EMS following the resident's fall if he/she showed signs of injury. They could not recall who the nurse was as he/she was through an agency and the facility has stopped utilizing agency staff. The Administrator was told the resident was not injured during the transfer. They staff should not have moved the resident following the fall. During an interview on 6/3/25 at 11:34 A.M., the facility's Medical Director said she was not familiar with the resident. However, staff should have contacted EMS prior to moving the resident if he/she showed signs of an injury. 2. Review of the facility's Total Lift Transfer policy, reviewed on 11/28/22, showed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Policy: The facility will utilize a Total Lift Device on residents who are unable to assist with transfers; -Responsibility: Employees, nursing administration, Director of Nursing; -Procedure: -Measure resident for appropriate sling size according to Manufactures Guidelines; -Explain the procedure; -Ensure lifting device battery is charged; -Clear an unobstructed path for the lift device; -Ensure appropriate room to pivot the lift; -Position the lift near the receiving surface; -Place the lift at the correct height; -Lock the bed/chair wheels; -Inspect equipment; ensure in good condition (sling/straps); -Place sling under the resident; -Lower lift for easy attachment of the sling; -Position the sling under the resident with the base of the sling at the base of the resident's spine, top of the sling at the top of the head; cross straps prior to hooking the straps of the lift; -Match the corresponding colors on each slide of the sling and observe that all sling loops are securely connected; -Lift resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution; -Evaluate resident's level of comfort and observe for signs of pinching or pulling of the skin; -Standing next to the resident, press the up button on the lift controls to slowly raise the lift to the height necessary to clear the surface. maintain contact with the resident to guide/steady the resident during the lift transfer, as necessary; -Standing next to resident use the down button on the lift control to slowly lower the resident to the desired surface, guide/steady as necessary; -Detach the sling from the lift ensuring the bar of the lift does not touch resident; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Move the lift away from the resident; -Lifting from the chair: Lock the wheels of the chair; -Attach the sling to the lift using color coded straps; cross straps prior to securing to the lift; -Open the legs of the lift using the hand controls; -Raise resident using the hand controls; -Safely lower resident to the chair ensuring proper placement; -Unhook sling from lift ensuring the lift bar does not touch resident; -Lifting from the floor: Place the sling centered under resident; -Open the legs of the lift; -Attach the sling to the lift using color coded straps; cross sling straps prior to securing to the lift; -Raise resident from the floor to the desired surface. Review of Resident #1's annual MDS, dated [DATE], showed: -Moderate cognitive impairment; -Wheelchair for mobility device; -Dependent to chair/bed-to-chair transfer; -Diagnoses included multiple sclerosis (MS, chronic disease of the central nervous system) and paraplegia (paralysis of the lower parts of the body). Review of the resident's care plan, in use at time survey, showed: -Focus: Limited physical mobility related to MS, paraplegia and needs assistance with meals; -Goals: Will demonstrate the appropriate use of adaptive devices to increase mobility; -Will remain free of complications related to immobility, including contractures, thrombus formation (blood clots), skin breakdown, fall related injury; -Interventions: Hoyer lift transfer with medium size sling, provide supportive care, assistance with mobility as needed, document assistance as needed; -Focus: Resident is at risk for falls related to deconditioning; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Goal: Resident will not sustain serious injury through the review date; -Interventions: Anticipate and meet the resident's needs, follow facility fall protocol. Observation on 6/2/25 at 5:05 A.M., showed CNA N and LPN O entered the resident's room to transfer the resident using a Hoyer lift. The Hoyer sling or pad was applied under the resident while in bed. The resident was not properly adjusted prior to lifting the resident. CNA N adjusted the resident's head and feet with one hand while controlling the lift and the resident was suspended in the air. The resident's wheelchair was placed away from the bed. The resident was dangling and spun around while the lift was wheeled closer to the wheelchair. LPN O did not spot and support the resident. The resident was lowered to the wheelchair without being adjusted and repositioned comfortably. During an interview 6/3/25 at 10:59 A.M., CMT (Certified Medication Technician) D said Hoyer lift transfers required two staff to provide residents' safety. The staff should make sure they were using the correct size of the sling or pad. One staff would operate the Hoyer while the other would make sure the resident would not slide out of the sling, and make sure to hold and support the resident's head and legs. The staff should make sure the resident was comfortable in the chair or bed after transfer. During an interview on 6/3/25 at 11:28 A.M., LPN C said two staff were required at all times to transfer residents using Hoyer lift. One staff can spot and keep the resident stable while the other operates the Hoyer. The resident's head, legs and body should be assisted and kept steady, and without flopping to the chair. The resident's wheelchair should be positioned parallel and close to the bed. During an interview on 6/3/25 at 5:25 P.M., the Corporate Nurse said Hoyer-transferred residents should have two staff at all times, providing residents' safety. The staff should make sure the Hoyer's legs were opened when used, and the resident's body should be adjusted and leveled. The resident should be supported, avoiding being dangled in the air and providing a minimum distance from the bed when lifted up. She expected staff to provide the residents with safe transfer at all times and to follow their mechanical transfer policy. MO00238874 MO00237238 MO00254710

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was administered Triumeq (Abacavir-Dolutegravir-Lamivudine, a prescription medication used to treat human immunodeficiency virus (HIV, a virus that attacks the body's immune system)) as ordered (Resident #105). In addition, the facility failed to ensure the prescribing Infectious Disease (ID) physician was notified timely when the medication was not available. The facility failed to have a process in place to follow up timely on prior authorizations resulting in the resident missing multiple doses. The sample was 24. The census was 121. Review of the facility's Medication Administration - Prep and General Guidelines policy, dated 12/17, showed: -If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the Medication Administration Record (MAR) for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record; -If a vital medication is withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response; - If an electronic MAR system is used, specific procedures required for resident identification, identifying medications due at specific times, and documentation of administration, refusal, holding of doses, and dosing parameters such as vital signs and lab values are described in the system's user manual. These procedures should be followed and may differ slightly from the procedures for using paper MARs. Review of the facility's Physician Orders Policy, dated last reviewed 9/28/22, showed: -Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, state and federal guidelines; -Physician orders shall be provided by Licensed Practitioners (Physicians, Nurse Practitioners (NP) and Physician Assistants (PA)) authorized to prescribe orders; -Medications will be ordered from the pharmacy to ensure prompt delivery. Review of Resident #105's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 3/14/25, showed: -Moderately impaired cognition; -No behaviors or rejection of care; -Diagnoses included HIV. Review of the care plan in use at the time of survey showed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: The resident has impaired immunity related to acquired immunodeficiency syndrome (AIDS, late stage of HIV that occurs when the body's immune system is badly damaged because of the virus); -Goal: The resident will not display any complications related to immune deficiency; -Interventions included: -Encourage fluid intake and adequate rest to boost the immune system; -Monitor/document and report as needed any signs and symptoms of infection: fever; redness; drainage or swelling around wounds or catheter sites (site where a catheter enters the body); cough, respiratory symptoms; dysuria (painful urination), hematuria (blood in the urine), flank pain (discomfort felt in the body between the ribs and the hips) and foul smelling urine; -Monitor/document and report as needed abnormal laboratory values; -Monitor/document and report to the Medical Doctor (MD) signs and symptoms of delirium: changes in behavior, altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness and agitation, altered sleep cycle; -The resident is at risk for contracting infections due to impaired immune status. Keep the environment clean and people with infection away. During an interview on 5/28/25 at 3:10 P.M. and 5/30/25 at 2:25 P.M., the resident and the resident representative (RR) said the resident admitted to the facility on [DATE] and the facility did not start the Triumeq until 3/14/25. The facility went through their pharmacy to get the medication. The resident went for a doctor's appointment on 5/20/25 and had labs drawn. When the labs came back it showed the viral load (the amount of virus present in a person's blood or other bodily fluids) was over one million and the CD4 (specific type of white blood cell that plays a critical role in the immune system) was low. This should have been the opposite if the medications were being administered. The ID office tried to call the facility on 5/22/25, but they were unable to reach the nurse. PA I called the RR who told the Director of Nursing (DON), and she called the ID office. The ID office was able to get the medications covered and sent over to the facility on 5/23/25. The resident did not receive his/her medications for a month and half. The RR was told there was an issue with the insurance. The facility did not notify the RR the medications were not being administered. The facility told the RR not to bring any medications, whatever the resident needed would be provided by the facility. Review of the transfer orders for the receiving facility, dated expected discharge date [DATE], showed: -A physician order for Triumeq, take one tablet by mouth once daily; -A physician order for Triumeq, take one tablet by mouth once daily. Review of the MAR, dated 3/7/25 through 3/14/25, showed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A physician order for Triumeq 600-50-300 mg, give two tablets via (percutaneous endoscopic gastrostomy (peg)-tube (feeding tube)) in the morning for antiviral. Order date was 3/8/25 and discontinued on 3/14/25; -On 3/8 through 3/10 and 3/12/25 staff documented NA (not administered see nurses notes); -On 3/11 and 3/13/25 staff documented as administered; -On 3/14/25 staff documented OO (out of facility); Review of the progress notes dated 3/7/25 through 3/14/25, showed: -On 3/7/25 at 8:29 P.M., resident was admitted today at 7:50 P.M. from hospital with diagnoses of AIDS and neutropenia acute respiratory failure (a serious condition where the lungs are unable to adequately oxygenate the blood). Medications verified with primary physician, no new orders; -On 3/8/25 at 11:13 A.M., Triumeq, new admit, medication on order; -On 3/9/25 at 10:12 A.M., Triumeq, new admit, medication on order; -On 3/9/25 at 11:44 A.M., Triumeq, called pharmacy regarding status, requires approval due to high cost, DON aware; -On 3/10/25 at 10:20 A.M., Triumeq, awaiting pharmacy delivery; -On 3/10/25 at 7:21 P.M., NP note, showed chief complaint: Resident was a new admit to facility. The NP did not document the medication was on order; -On 3/11/25 at 2:50 P.M., Triumeq, medication needs approval before they (the pharmacy) will send it out; -On 3/12/25 at 9:01 A.M., Triumeq, awaiting pharmacy delivery; -On 3/14/25 at 12:48 P.M., resident came back from MD appointment. Update regarding medication dosage, Triumeq one tablet once daily via gastrostomy tube (g-tube, a tube placed through the abdomen into the stomach to provide nutrition, hydration and medication). MD notified; -There was no documentation showing the RR was made aware there was a gap in the medication being administered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ID office notes, showed on 3/14/25 at 3:23 P.M., the ID office called the facility on Tuesday 3/11/25 to ensure patient was receiving medications properly. Waited on call for close to two hours. Was told at that time that patient had yet to receive Triumeq. ID office attempted to call on 3/13/25 and waited on hold for approximately 40 minutes. Was unable to speak with a nurse at that time. Patient brought paperwork from facility to appointment today. According to paperwork patient began taking all medications upon admission on [DATE]. Called facility and asked to speak with a Nurse Supervisor. Nurse Supervisor pulled dispense report and reported the Triumeq was started on 3/13/25. Two tablets of Triumeq were given instead of one. Gave a verbal order to decrease dosing to one pill of Triumeq once daily. Review of the MAR, dated 3/15/25 through 3/31/25, showed: -A physician order for Triumeq 600-50-300 mg, give one tablet via peg tube in the morning for HIV; -On 3/15 and 3/30/25 staff documented NA. Review of the progress notes dated 3/15/25 through 3/31/25, showed on 3/15/25 at 8:30 A.M. and on 3/30/25 at 11:18 A.M., were left blank. Review of the ID office notes, showed, date of service 3/20/25 at 2:54 P.M., RR, called earlier this week with concerns that the resident had decompensated. According to the RR, the resident was transitioned back to nothing by mouth (NPO) as he/she was not swallowing, and he/she was unable to participate in therapy due to both physical and mental decline. Spoke with the Nurse Supervisor as well as the resident's nurse on 3/19/25. The Nurse Supervisor stated that the resident was seen on 3/18/25 by the Medical Director who did not have any concerns and did not place any new orders. Verified the resident was getting medications as prescribed. Review of the MAR dated 4/1/25 through 4/30/25, showed: -A physician order for: Triumeq 600-50-300 mg, give one tablet via peg tube in the morning for HIV; -No documentation by staff on 4/11/25; -On 4/20, 4/22 through 4/27 and on 4/30/25, staff documented NA. Review of the progress notes dated 4/1/25 through 4/30/25 showed: -On 4/11/25, there was no documentation for the medication; -On 4/20/25 at 11:22 A.M. Triumeq, on order; -On 4/21/25 at 3:07 P.M., NP in to see resident, new orders obtained, diet consult, count meal consumption for next three days and change tube feeding from continuous to on at 7:00 P.M. and off at 7:00 A.M. The note did not show the NP was aware the medication was on order; -On 4/21/25 at 6:32 P.M., NP note did not show the medication was on order; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/22/25 at 3:25 P.M., Triumeq, unavailable; -On 4/23/25 at 8:08 A.M., Triumeq, drug unavailable, on order; -On 4/24/25 at 7:00 A.M., Triumeq, on order; -On 4/24/25 at 5:56 P.M., NP note did not show the medication was on order; -On 4/25/25 at 9:30 A.M., Triumeq, medication not available; -On 4/26/25 at 9:23 A.M. Triumeq, note was blank; -On 4/27/25 at 11:22 A.M., Triumeq, on order; -On 4/28/25 at 6:21 P.M., NP Notes/ Findings: Resident has an extensive past medical history. Resident seen today for compliance with medication and effectiveness of treatment, on exam today resident denies any acute findings and no acute finding noted, resident maintains Triumeq one daily; Plan: Maintain Triumeq one daily, to follow up with Infectious disease; -On 4/30/25 at 9:06 A.M. Triumeq, medication not available, on order; -Staff did not document the ID physician was notified the medication was not being administered as ordered; -Staff did not document the resident or RR were made aware the medication was not being administered. Review of the MAR dated 5/1/25 through 5/26/26, showed: -A physician order for Triumeq 600-50-300 mg, give one tablet via peg tube in the morning for HIV; -On 5/3 through 5/6, 5/8 through 5/10, 5/12, 5/17 through 5/22/25 staff documented NA; -On 5/7/25 staff left blank. Review of the progress notes dated 5/1/25 through 5/26/25, showed: -On 5/1/25 at 6:45 P.M., NP note did not show the medication was on order; -On 5/3/25 at 11:07 A.M., Triumeq, high-cost medication, n/a; -On 5/4/25 at 9:10 A.M., Triumeq, note was blank; -On 5/5/25 at 8:47 A.M., Triumeq, high-cost medication not available; -On 5/6/25 at 9:57 A.M., Triumeq, on order; -On 5/8/25 at 10:37 A.M., Triumeq, med not available; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/9/25 at 8:59 A.M., Triumeq high-cost medication not available; -On 5/10/25 at 10:01 A.M., Triumeq note was blank; -On 5/12/25 at 9:19 A.M., Triumeq, high-cost medication not available; -On 5/17/25 at 8:39 A.M., Triumeq high-cost medication not available; On 5/18/25 at 9:58 A.M., Triumeq high-cost medication not available, called pharmacy regarding status, not covered by insurance, MD made aware; -On 5/19/25 at 9:01 A.M., Triumeq, high-cost medication not available; -On 5/20/25 at 9:56 A.M., Triumeq, medication not available; -On 5/21/25 at 10:43 A.M., Triumeq, high-cost medication not available; -On 5/22/25 at 10:16 A.M., Triumeq, high-cost medication not available; -Staff did not document the ID physician , the resident/RR were notified the medication was not administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ID office notes, showed: Visit date: 5/22/25, no time was documented, Concerns were brought to our attention that patient's insurance was not covering Triumeq anymore. A script for Triumeq was sent to hospital pharmacy to look into claim and any Issues that would arise. Triumeq at hospital pharmacy: $4,676. 91 rejections for cost exceeds maximum. Requested a maximum cost override on the Triumeq. A maximum cost override would be required every single month for pharmacy benefits. Insurance cannot tell ID office what the maximum cost is or why a monthly override was needed on a chronic disease medication. The representative confirmed that there have been zero paid claims on Triumeq for 2025 under the patient's pharmacy benefits. Override was approved and pharmacy processed for $0.00. Patient's viral load came back at over 1 million. Called facility this morning at approximately 8:15 A.M. The facility was able to tell PA I Triumeq was on patient's medication list. The facility was not able to provide the ID office with a dispense report. The facility claimed there was an insurance problem and patient last received his/her Triumeq on 5/17/25. The individual on the phone asked that PA I call back to speak with the DON. Called the facility and asked to be transferred to the DON. Sent to the voice mail, left a message. Immediately called back and asked to speak with an available nurse. Was transferred which went directly to voice mail, left a message. PA I attempted to call facility to inquire about fill history and dispense report as resident's recent HIV viral load resulted as over one million. Waited on hold for 20 minutes. A nurse answered and responded I don't have time for that. I am giving hand off. Was put back on hold. Waited an additional 15 minutes prior to hanging up and calling back. Called the facility again and told the individual at the front desk that it was an urgent matter. The individual said he/she paged the DON, but didn't hear back from anyone and proceeded to hang up the phone. Called the RR with patient's test results. Explained that the results are very concerning because this means patient has been off his/her Antiretroviral therapy (ART, combination of medication that manages and suppresses HIV). RR drove to the facility, found the DON and had her call the ID office. Explained patient's test results to DON and explained that it would be PA I's assumption that the patient has been off his/her ART for over a month. This is extremely concerning due to patient's current status and recent past medical history. The prescribing physician at the ID office was not made aware of any delays or gaps in treatment. The RR was not made aware either. The DON said there was a cost concern with the drug. Stated that their physician did a peer to peer and that the drug was denied. Explained that our facility was able to send the drug to our pharmacy and that it was processed with a $0.00 co-pay. PA I would like to send a courier with the medication to ensure patient was re-started on the medication ASAP. PA I will need to know exactly how long the patient was without his/her ART. The DON said the patient last took Triumeq on 5/2/25. Requested the facility fax a fill history, complete dispense report and any documented communication regarding the drug Triumeq. The Assistant Director of Nursing (ADON) called this office at approximately 4:00 P.M. and stated the patient and RR were made aware of patient's gap in medication and were informed on multiple occasions outside medication was needed to be brought into the facility. It is noted that the patient does not have capacity at this point in time. RR stated he/she was never made aware patient was not receiving ART and in fact had noted concerns about patient's increased confusion and steps backwards. During an interview on 5/29/25 at 7:40 A.M. and 12:12 P.M., Certified Medication Technician (CMT) D said if a medication was not available, he/she would reorder the medication using the computer system. If the medication was a stock medication, he/she would go to the supply room and obtain the medication. If the medication was a prescription medication, he/she would try to obtain the medication from the emergency (e) kit. If the medication was not in the e-kit, he/she would tell the nurse, and the nurse would call the pharmacy and the doctor. The past two weeks or so, the resident had been getting his/her medication. Prior to that, the nurses were administering the medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/25 at 9:15 A.M., CMT G said if a medication was not available, he/she would check the stat kit. If the medication was not available in the e-kit, he/she would call the pharmacy and report it to the nurse and do what the nurse told him/her to do. During an interview on 5/29/25 at 11:50 A.M. Registered Nurse (RN) H said if a medication was not available for two doses, he/she would document it on the MAR, call the pharmacy and notify the physician. Initially the pharmacy provided the resident's medication. After that, there was an issue with the insurance. He/She placed a call to notify the doctor, but he/she could not recall if the doctor called back or if he/she passed it on to the next shift. He/She did not notify the RR because the RR came late to the facility. He/She did not know if the resident was currently receiving his/her medications or not. During an interview on 5/29/25 at 10:24 A.M. Pharmacist F said new orders are submitted to the pharmacy electronically. If a medication was not available, the facility would usually call the pharmacy, and they will trouble shoot the problem. Medications were refilled through the computer system. If a medication needed a script the facility could notify the physician themselves or call the pharmacy who would notify the physician. On 3/12/25 the pharmacy sent out the order for two tablets every morning for a 15-day supply. Triumeq was not available in the facility emergency kit (e-kit, a limited supply of medications for immediate use in case of emergencies when pharmacy services are not readily available). Pharmacist F said the resident had a second order, Triumeq one tablet every morning. The order was stuck in the prior authorization batch and was not sent out. During an interview on 5/29/25 at 10:50 A.M., PA I said she was aware there would be a delay in the facility obtaining the resident's medication initially. This was because the resident was admitted to the facility on a Friday and Triumeq was not a medication the pharmacy usually had on their shelves. The pharmacy would need to order the medication, but they would expect the medication to be at the facility by Monday or Tuesday. PA I called the facility to verify the medications had been received and was told the medication had been started. The facility never called and reported there was a gap in the resident's medication. On May 20, 2025, the residents' labs were drawn and showed his/her viral load was 1.2 million. If the resident was receiving his/her medication the viral load should be fully suppressed, but in the resident's case the viral load could be 100-200 over. As the prescribing doctor for the medication, he/she would have expected to have been notified when the medication was not administered. If the facility would have notified her the office's pharmacy access specialist, who worked with the pharmacy to get the medications, could have looked into it. Once the ID office was made aware the resident was not receiving his/her medication, the medication was delivered to the facility within a few hours. The facility said their pharmacist talked with their doctor and the pharmacy was waiting on the doctor to sign off on the medication. The doctor said she signed off on the medication. The facility said they told the resident he/she was not receiving the medication. PA I did not believe the RR was aware the resident was not receiving his/her medications because the RR knew the ID office had resources to obtain the medications. If the RR knew the resident was not receiving the medication he/she would have contacted the office. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/25 at 1:21 P.M., and on 6/3/25 at 11:10 A.M., Physician J said if a medication was not available, she would expect the nurse to call the pharmacy to find out the reason and notify the DON and to notify her. Staff could notify her after two or three missed does up to a week, depending on the medication. It was not acceptable for staff to document NA, without documenting what they did, such as calling the pharmacy. Documenting was important for better communication so the next nurse would know what had been done. The resident was admitted with Medicare A services and was supposed to discharge home. The DON called her and asked if they could change the medication to something else. Physician J told the facility to contact the ID office as she was not an HIV specialist. Another time, she spoke with the nurse who said the resident was receiving his/her medication and the ID office did not want to change the medication. Later, she was told insurance would not pay for the medication. This medication was very expensive and she did not expect for the facility to have to pay for it. It took time to submit an appeal to try to get the medication covered and/or get the resident set up with a clinic. The facility did not have to notify the ID office if they notified Physician J the resident did not receive his/her medications. Physician J would expect the staff to follow physician orders. If the viral load was one million that could indicate the resident was not receiving his/her medications, but she did not know the resident's prior viral load. The facility could have set up an appointment with ID. During an interview on 5/29/25 at 1:55 P.M., with the DON, ADON and the Administrator, the DON said if a medication was not available, staff should check the pyxis (an automated medication dispensing system) to see if the medication could be pulled and given. If the medication was not available, the nurse should call the pharmacy and notify the doctor after one missed dose. After the doctor was notified, the nurse would not have to notify the doctor for each missed dose, depending on the medication. This may be be documented. Sometimes staff did not document if the doctor or NP was at the facility. Staff should document NA for not administered on the MAR and the reason it was not administered. Notification of the RR would depend on if the resident was their own responsible party or not. The resident brought his/her own medication from home and the facility used it until they found out they could not use it. The resident's RR was going to bring in the medication, then he/she did not bring it in. The RR would say he/she was going to bring it in. The facility's doctor was working with the facility's pharmacy, and the doctor signed off on the medication. The medication was ordered from the facility's pharmacy. The RR was aware there was a delay in the resident's medication in April and that's when he/she was supposed to bring the medication in from home. On 5/8/25 the ADON said she texted the facility's doctor to update her, and the doctor said to follow up with ID office. The ADON said she talked with ID office, and they said they would pay for the medication. The medication was sent out on 5/22/25. These communications were not documented. The DON said if a resident did not receive his/her antiviral medication, she would suspect it could increase the viral load. The Administrator said the facility knew the cost of the medications when they accepted a resident. If they accepted a resident, it was their responsibility to pay for the medications. When staff documented on a high-cost medication, the computer automatically entered high-cost medication because it was prepopulated. The DON said she felt the facility did everything correct on their end. They notified the doctor, the pharmacy, the RR and ID office. During an interview on 6/3/25 at 5:25 P.M., the Corporate Nurse said she would expect for the staff to follow physician orders and the facility's policies and procedures. On 5/30/25 and on 6/3/25, the surveyor requested any text messages the facility had showing the physician/ID office was notified the resident was not receiving the medication per MD order. As of 6/3/25 at 6:00 P.M. no documentation was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program when staff failed to change gloves, wash or sanitize hands and wear gowns during care for residents on enhanced barrier precautions (EBP, precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO, microorganisms that are resistant to one or more classes of antimicrobial agents) for four residents (Residents #105, #66, #47 and #1). In addition, the staff failed to disinfect the accucheck machine (used to test blood sugar) properly for one resident (Resident #47). Furthermore, staff placed unbagged dirty linens and briefs on the floor during care of two residents (Residents #105 and #66). Moreover, the facility failed to ensure newly hired employees completed the 2-step Mantoux tuberculin skin test (TST), used to test for latent tuberculosis (TB) infection, as required for 9 out of 10 employees residents sampled. The sample was 24. The census was 121. Review of the facility's Enhanced Barrier Precaution (EBP) sign, showed: -Everyone must clean their hands, including before entering and when leaving the room; -Providers and staff must also: wear gloves and gown for the following high contact resident care activities: -Transfers; -Providing hygiene; -Changing briefs or assisting with toileting; -Wound care: any skin opening requiring a dressing. Review of the facility's Hand Hygiene policy, reviewed on 4/28/22, showed: -Policy: The Facility will provide guidelines to Employees on proper handwashing and Hand Hygiene techniques that will aid in the prevention of the transmission of infections; -Responsibility: All Employees, Nursing, Nursing Administration, Director of Nursing; -Procedure: Employees will be trained and receive ongoing education on the importance of Hand Hygiene in preventing the transmission of Healthcare-Associated Infections (HAI); -Hand Hygiene should be performed following the Clinical Indications: -Before/After providing Care; -Before/After performing Aseptic Task (such as placing an indwelling device); -Contact with blood, body fluids, or contaminated surfaces; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Before/After applying/removing gloves/Personal Protective Equipment (PPE); -After handling soiled lines/items potentially contaminated with blood, body fluids, or secretions. Review of the facility's Handling Linen policy, reviewed on 7/2/24, showed: -Policy: Linen and laundry should be handled, transported, and stored to prevent the spread of infection; -Employees shall be educated in proper techniques to handle, store, and transport both soiled and clean linens and laundry. No policies for multi-use machines and employee's TB testing were provided following requests from the facility. 1. Review of Resident #105's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/14/25, showed: -Moderately impaired cognition; -Feeding tube while a resident; -Frequently incontinent of bowel and bladder; -Required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene; -Diagnoses include medically complex condition and human immunodeficiency virus (HIV, a virus that attacks the body's immune system). Review of the care plan in use at the time of survey, showed: -Focus: Activities of Daily Living (ADL, grooming, dressing, bathing and personal hygiene) self-care performance deficit activity intolerance, fatigue, impaired balance; -Goal: ADL Function: resident requires assistance with ADL care and mobility. At facility on a skilled rehab stay to increase in strength, mobility, endurance, and independence; -Interventions included: toilet use: one assist. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/2/25 at 5:45 A.M., showed an EBP sign and a caddy with PPE hanging on the resident's door. The resident lay in bed, Certified Nurse Aide (CNA) L entered the resident's room, performed hand hygiene and put on gloves. The CNA pulled the cover down and unfastened the brief and provided peri care (cleansing between the legs and buttocks area), the resident turned onto his/her side and the CNA finished cleaning the resident. The CNA removed the resident's brief and his/her gloves and placed them on the floor. He/She put a new pair of gloves on and put a new brief on the resident. Then, he/she made the resident comfortable in bed and picked up the soiled brief and gloves off the floor and put them in a trash bag and removed the trash from the room. The CNA failed to wear a gown while providing direct resident care. 2. Review of Resident #66's admission MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included anemia (decrease in number of red blood cells), high blood pressure, obstructive uropathy (any blockage or impediment that prevents the normal flow of urine through the urinary tract) and diabetes; -Indwelling catheter (a sterile tube inserted into the bladder to drain urine); -One Stage two pressure ulcer (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough (dead tissue separating from living tissue), may also present as an intact or open/ruptured blister); -One Stage three pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed) Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling); -Two unstageable wounds-slough and/or eschar (dead tissue): known but not stageable due to coverage of wound bed by slough and/or eschar; -One unstageable-deep tissue: suspected deep tissue injury in evolution. Review of the care plan, in use at the time of survey, showed: -Focus: resident had an unstageable pressure wound to left heel, Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) to right heel, unstageable to sacrum, Stage 3 to left buttock, and Stage 2 to right buttock; -Goal: to remain without complications over through the next review; -Interventions: provide treatment per current order. (continued on next page)

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	265834	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/2/25 at 7:05 A.M., showed an EBP sign and PPE on the resident's door. The resident lay in bed with his/her heel boots in place. The indwelling catheter was draining to gravity on the window side of the bed. Licensed Practical Nurse (LPN) K entered the room, performed hand hygiene and put gloves on, no gown was put on. He/She removed the resident's heel boots and changed the resident's dressing on both of his/her heels. LPN K removed the bed linens that were at the foot of the bed and placed them in a pile on the floor and said, I know linens should not be on the floor; it is what it is. The nurse moved the resident's urinary gravity bag to the other side of the bed and assisted the resident to roll onto his/her side. The nurse removed his/her gloves and left the room, to obtain more linens. When he/she returned to the room, he/she had on gloves, gown and a face mask on and said now that I'm all gowned up, I am good. The nurse provided peri care and wound care to the resident's buttocks. After care was provided, the nurse placed the dirty linens that were on the floor in a plastic bag and removed them from the room. 3. Review of Resident #47's admission MDS, dated [DATE], showed: -Cognitively intact; -Dependent (helper does all the effort. Resident does none of the effort to complete the activity) for chair/bed-to-chair-transfer; -Diagnosis of end stage renal disease (ESRD, chronic irreversible kidney failure); -Dialysis while a resident. Review of the care plan in use at the time of survey, showed: -Focus: ADL self-care and mobility performance deficit related to weakness and activity intolerance; -Goal: will maintain current level of function with ADLs through the review date; -Interventions included: transferring: dependent. Observation on 6/2/25 at 5:22 A.M., showed an EBP sign and a caddy with PPE hanging on the resident's door. LPN K and CNA L entered the resident's room and performed hand hygiene and put on gloves. The resident lay in bed, with a mechanical lift pad under him/her. The CNA and the nurse attached the lift cloth to the mechanical lift and transferred the resident from the bed to the chair. Then, they unfastened the lift cloth and positioned the resident in the chair. Both staff failed to wear a gown during the transfer. Observation on 5/29/25 at 8:00 A.M., showed LPN A removed the blood sugar machine from the medication cart and entered the resident room. He/She performed the blood sugar and returned the blood sugar machine to the medication cart without cleaning it. The blood sugar machine was placed on top of the medication cart without placing a barrier between the top of the cart and the machine. At 8:20 A.M., LPN A took the same blood sugar machine into another resident's room without cleaning it and performed the blood sugar. The blood sugar machine was placed on to the top of the medication cart, without cleaning it or placing a barrier between the blood sugar machine and the top of the cart. (continued on next page)

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